CASES FROM THE PHONE

#WHATDOIDODOC

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SCHWARTZ LASER EYE CENTER

DR.BLOOMENSTEIN'S DISCLOSURE

- Presenter is on speakers panel/Consultant of Alcon, Allergan, AMO, Bausch + Lomb, Akorn, Odyssey, Tear Lab, OCuSOFT, BlephEx
- President of MRB Eye Consultants
- Past-President of the Optometric Council on Refractive Technology (OCRT)
- AOA CE Chairman
- Presenter has NO financial interest in any products mentioned

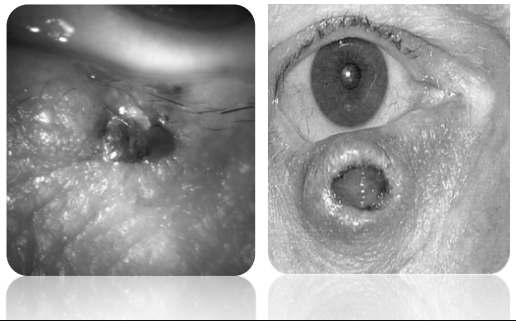
TOP TEN MALPRACTICE

- 1. Failing to listen to patients, spend adequate time with them, and communicate empathetically with them
- 2. Maintaining illegible or incomplete documentation
- 3. Failure to establish standards of conduct for office staff
- 4. Being inaccessible to patients
- 5. Failure to order and follow up on indicated tests or delay in ordering such tests
- 6. Failure to refer when appropriate, failure to track referrals, and failure to communicate with referring physician .
- 7. Inappropriately prescribing medications .
- 8. Improper care of patients during emergency situations .
- 9. Failure to obtain informed consent .
- 10. Allowing noncompliant patients to take charge

CAUTION…

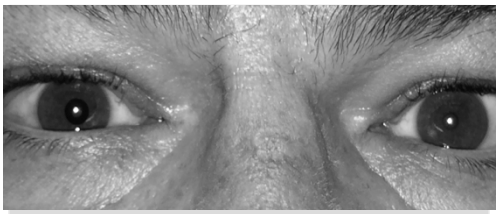
- American Academy of Pediatrics, showing there were 781 telephone treatment malpractice claims settled with an average payout of $269,000 between 1985 and 2004
- Diagnosing a patient over the phone implies a pre-existing relationship
- You get many patients who look like they have something simple, but only after being there and looking at them over time, they have something entirely different,

SOME PICS ARE GROSS!



CONFUSING

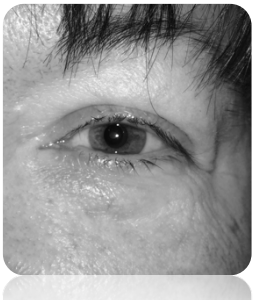
LIKE THIS….



ANISICORIA?

BLOWN PUPIL??

KAMRA INLAY



CASE

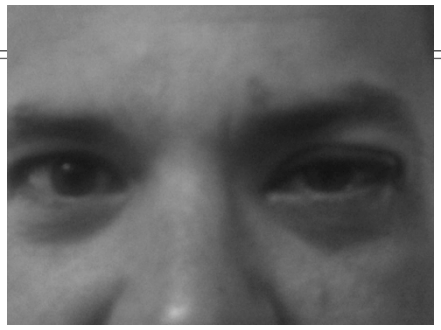
NATURAL CROSS LINKING

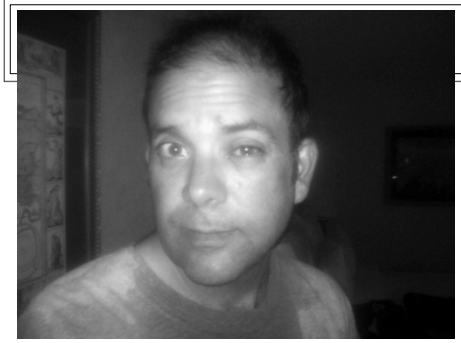
SOME PICTURES ARE JUST SCARY!

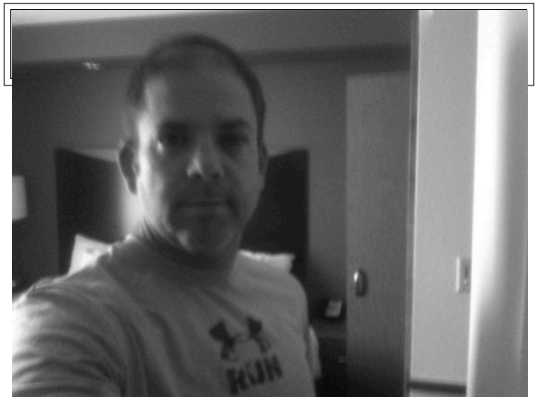
DR. DEREK CUNNIGHAM

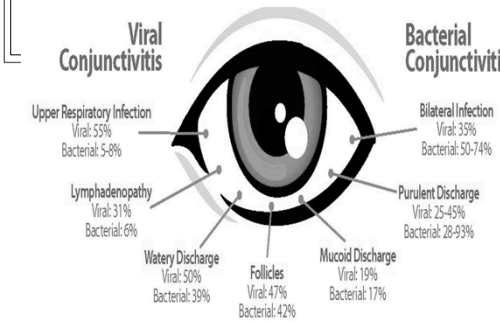
CASE

MORE SELFIES

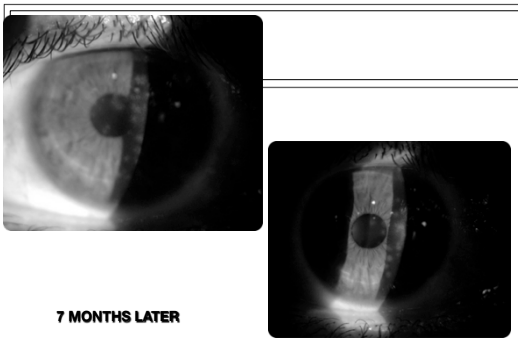








[1] O'Brien TP, Jeng BH, McDonald M, Raizman MB. Curr Med Res Opin 2009;25(8):1953-1961. [2] Fitch CP, Rapoza PA, Owens S. Ophthalmology 1989;96:1215-1220. [3] Gigliotti F, Williams WT, Hayden FG. J Pediatr 1981;98:531-536.



7 MONTHS LATER

VIRAL CONJUNCTIVITIS TREATMENT

- Supportive therapies
- Decontamination at home and hand washing
- Isolation
- Anti-viral therapy
  - No FDA-approved drugs specific for the treatment of Adenoviral conjunctivitis
  - Off-label applications for some currently available drug therapies: **Povidone Iodide** and **Ganciclovir (Zyrgan)**

NO ANTIBIOTICS REQUIRED!

OFF-LABEL ADENOVIRAL TREATMENTS

Povidone Iodide (PVI)[1]

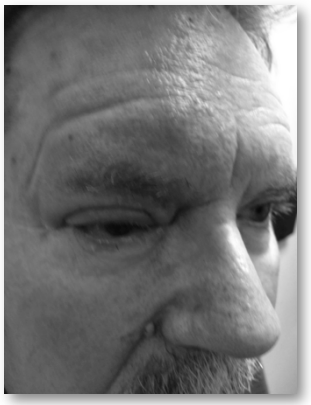
- PVI (0.8%) extinguishes infectivity of free Adenovirus after 10 minutes of exposure but is less effective against intracellular Adenovirus
- Isenberg et al found Povidone Iodide (1.25%) ineffective

Povidone Iodide (0.4%) – Dexamethasone (0.1%)[2]

- 9 eyes of 6 patients with confirmed Adenovirus enrolled
- 8/9 enrolled showed clinical resolution by day 4
- 6/6 patients with significant reduced DNA copies by day 5
- 5/6 culture positives with no infectivity by day 5

[1] Monnerat N, Bossart W, Thiel MA. Klin MonblAugenheilkd. 2006. 223(5): 349-352. [2] Pelletier JS, Stewart K, Trattler W, et al. Adv Ther, 2009. 26(8): 776-783.

CASE

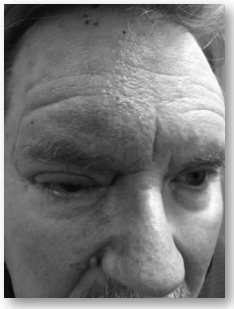


WHAT YOU THINK DR.?

- Herpes Zoster Ophthalmicus

HERPES ZOSTER

- Nearly 1 Million Americans develop herpes zoster each year
- Herpes Zoster Ophthalmicus (HZO) accounts for up to 25% of presenting cases
- Over 50% incur ocular damage

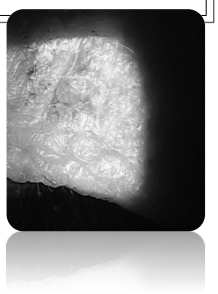


HUTCHINSON'S SIGN:

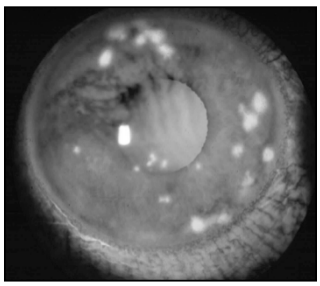
- Lesion on the tip of the nose
- Nasociliary branch of ophthalmic division of trigeminal nerve (V)
- Nasal means possibly ciliary (ocular) involvement

OCULAR FINDINGS:

- Conjunctivitis/Scleritis
- Pseudodendrites
- Neurotrophic keratitis
- Iritis
- Glaucoma
- ION, vein or artery occlusion
- Nerve Palsy



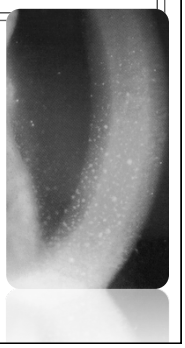
HERPES ZOSTER OPHTHALMICUS



Pseudodendrites

IRIDOCYCLITIS AND HZO

- Most common and most often overlooked ocular complication (43%)
- Highly elevated IOP
- Study by Thean, Hall & Stawall -clinical Ophthalmology Dec 2001
- 56% of patients developed glaucoma!!



TREATMENT: IRIDOCYCLITIS

- Pred Acetate 1% q1h or q2h
- Durezol (Difluprednate) 0.05% QID
- Lotemax Gel Long term
- Cycloplegia
  - Homatropine 5% bid
  - Cyclopentolate 1% bid

ALSO ADDED MEDICATION TO LOWER THE IOP-IF NEEDED!

- Diamox 500 mg (non-sequels)
  - after asking about sulfa allergies and kidney problems
- Beta-blocker gtts
  - after asking about heart rate and breathing problems
- Iopidine/Alphagan

TREATMENT OF HZO:

- Acyclovir 800 mg 5x/day
- Famvir 500 mg 3x/day or Valacyclovir 1000 mg 3x/day
- Advantages:
  - Easier to take 3x Vs. 5x
  - Decreased post-herpetic neuralgia, faster resolution of patient (Ormrod - Drugs June 2000)

TREATMENT:

- When should you begin therapy?
- Prior to 72 hours proven for Acyclovir (HE Kaufman)
- Not as critical for Valacyclovir or Famvir* (Ormrod)

TREATMENT:

- Duration?
- 7 days for most patients although newer studies suggest (Zaal - Am J or Ophthal. Jan 2001)
- 10 days for patients over age 66 due to shedding

NEW VACCINE: ZOSTAVAX

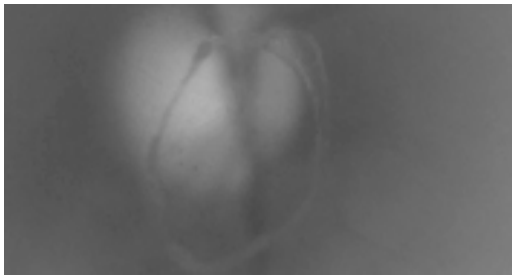
- Live attenuated zoster vaccine
- Indicated for patients above age 60 who had chicken box as a child but have not had shingles
- Doesn't work in 100% of cases and decreased effect with age

NEW VACCINE: ZOSTAVAX

- In the Shingles Prevention Study 38,000 patients 60 and older were enrolled
- 51.3% reduction of herpes zoster
- 61.1% reduction in the severity of herpes zoster
- 66.5% reduction in the incidence of post-herpetic neuralgia

CASE

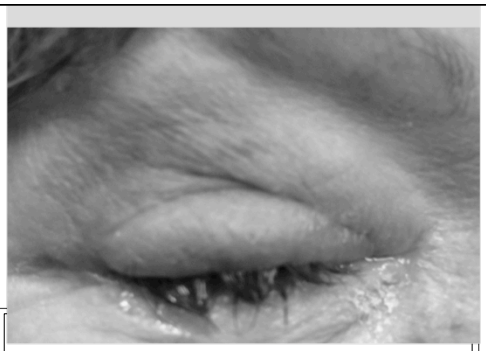
HELLO….MR. WIESS



SO WHEN WOULD IT BE BEST TO BRING AN ACUTE PVD BACK?

- 8-26% acute PVDs have an associated RB/RD
- AAO 2014 Guidelines: Depending on symptoms, risk factors, and clinical findings,
  - 1-8 weeks
- Rule of Thumb
  - Complicated PVD
    - MD in 2-4 weeks
  - Photopsia
    - 4-6 weeks
      - Double up visit: 2 w, 4w, 8w, 3 M…until done

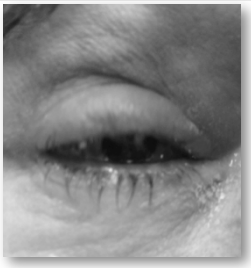
CASE

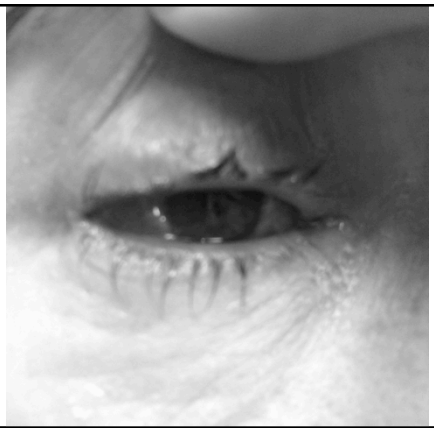


SO MANY THOUGHTS…

DIFFERENTIAL

- Allergic Conjunctivitis
- Bug Bite
- Bacterial Conjunctivitis
- Viral Conjunctivitis
- Preseptal Cellulitis
- Cellulitis
- Corneal Ulcer
- Foreign Body
- Hot tub
- Trauma





3 TYPES OF EYE BURNS

- Alkali Burns: These burns involve high pH chemicals, and thus are the most dangerous. They are powerful enough to penetrate the eye, and cause damage to its vital inner components. In the worst cases, they can lead to conditions like cataracts and glaucoma and may cause vision loss or blindness.
- Acid Burns: Lower pH burns that are less serious than alkali burns, but still dangerous. These burns are unable to penetrate the eye, but still may cause significant damage to the cornea, with the potential to cause vision loss.
- Irritations: These burns are neutral in pH

SYMPTOMS OF CHEMICAL BURNS

- Eye redness
- Eye irritation
- Eye pain
- Swelling of the eye
- Blurred vision
- Inability to open the eye
- Feeling of foreign objects in the eye

TELEPHONE TRIAGE TIPS

- Irrigation process begins on site before the patient seeks care.
- Use shower or hose if outside work place
- Attempt to determine the type of chemical that entered the eye(s).
- Attempt to determine if the patient is wearing contact lenses. Irrigation should not stop in an effort to remove contact lenses.
- A minimum of 20 to 30 minutes before the patient is brought to the office.
- When the patient is ready to make the trip to the ER or office, remind them to bring the container that held the offending chemical. Important information may be obtained from the labeling.
- If the injury occurred in the workplace, ask the patient to bring the MSDS (material safety data sheet) if available.
- If the injury occurred where there is no or limited access to water for irrigation, refer them to the nearest emergency room or your office, whichever is closer.
- Assist with dispatching emergency services as needed.

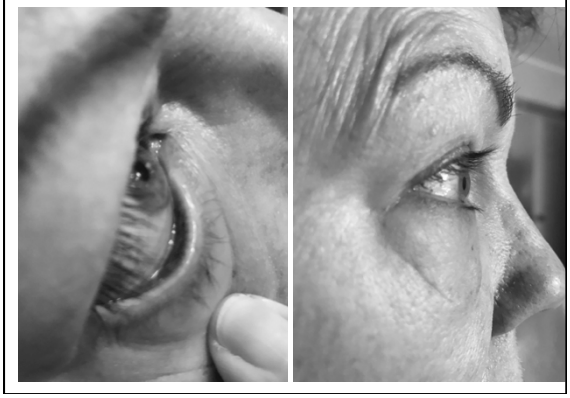
TREATMENT

- Assess the cornea and conjunctiva
  - Cornea intact-mild SPK
    - Prophylactic Antibiotic
    - Topical Steroid (Lotemax Gel)
    - Preservative Free Tears
    - Cycloplege for Pain
  - Cornea haze/Necrotic
    - All the above
    - Consider debridment
    - Sodium ascorbate drops (10%) Q1H while awake
    - Vitamin C-1000mg/day
    - Prokera

CASE

D.S. A PATIENT IN DISTRESS

- "I hate to bother you on a Saturday night but...
  - I have the start of a bump
- It's like the last time and I have an important event
- What can I do?"
  - Treatment:
    - Start warm compresses
    - Use massage
    - Let me know if it get's worse.....
- Day 2
  - I think it is worse....

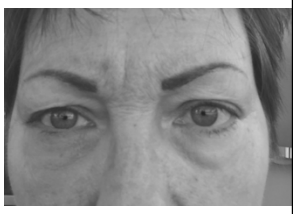


3 DAY

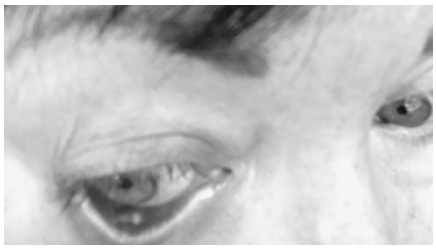
PATIENT REPORTS

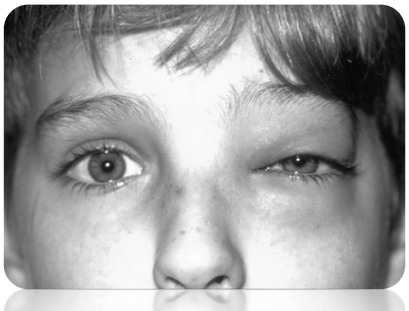
- Still Red
- Mild Pain
- Vision is blurry

- Treatment:
  - Augmentin 500mg bid
    - #20 tabs
  - Tobradex Ung
  - Massage bid-tid
  - Bruder Mask bid-tid

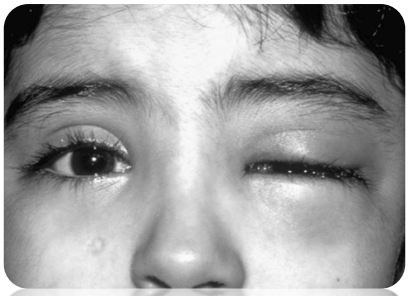


4 DAY





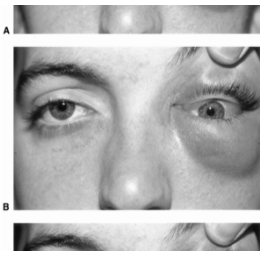
Preseptal cellulitis



Orbital cellulitis

ORBITAL CELLULITIS: SIGNS AND SYMPTOMS

- External signs: redness, swelling
- Motility impaired, painful
- ± Proptosis
- Often fever and leukocytosis
- ± Optic nerve: decreased vision, afferent pupillary defect, disc edema



ORBITAL CELLULITIS: MANAGEMENT

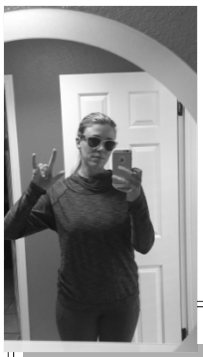
- Hospitalization
- Blood culture
- Orbital CT scan
- ENT consult if pre-existing sinus disease

ORBITAL CELLULITIS: TREATMENT

- IV antibiotics stat: Staphylococcus, Streptococcus, H. influenzae
- Surgical debridement if fungus, no improvement, or subperiosteal abscess
- Complications: cavernous sinus thrombosis, meningitis

CONCLUSION

- Be cautious
- Know who you are talking to, looking at , make prudent decisions
- Err on the side of conservatism
- Think worse case scenario



THANK YOU…

NOW GO TAKE A SELFIE…